

Southwest Ohio County Departments of Job & Family Services

Clermont County DJFS Office of Adult, Child and Family Stability 2400 Clermont Center Dr., Batavia, Ohio 45103

Phone: 513-732-7111

Fax: 513-732-7216, 513-732-7195 **Website:** www.acfs.clermontcountyohio.gov

EMPLOYMENT VERIFICATION REQUEST

JFS Worker:			Phone:		Date:		Return by:				
Employer Name:								Employee Name:			
Employer Address:								Social Security Number:			
City: State:				Zip:				Case Number:			
By applying for CDJI	FS programs,	the individ	lual has agi	reed tha	t the CDJFS r	nay contact	other persons	or organizat	ions to obtain the		
necessary proof of eli	igibility and lev	el of assis	tance. In ac	ldition, C	Ohio Revised C	ode 5101.3	7 authorizes the	CDJFS to m	nake investigations		
that are necessary in	the performand	e of their o	luties.								
			EMPLO	YER	TO COM	PLETE	 				
Dates of Employ	ment										
Corporate Name:				If employment has ended, also complete this section.							
•					ii employiii	ienii nas ei	iueu, aiso coi	iipiete tilis	Section.		
Name of Employment	Site:			Last Day Worked: Date Last		Pay Received:	Type of S	ype of Separation:			
Nume of Employment	Oito.					Bute East I by Neserveu.		Type or o	Type of coparation.		
Flori Do Model					100						
First Day Worked:							ess or Injury	s or injury r (specify):			
				_	signation			nlovment Re	nefits (specify):		
Date First Pay Receive	ed:			Discharged			ible for Post-Employment Benefits (specify):				
					g-u						
List interruption or leave period during employment.				Strike Start Date:		Strike End Date	e: Effec	Effective Lockout Date:			
From Date: To Date:											
Rate/Hours/Pay I	Frequency										
Current Hourly Rate: Day of Week Paid: Pay Period F											
			Weekly		Twice Monthly				ed to be worked in the future		
			Biweekly	/ <u></u> 01	ther (Specify) _		_ Worked	routinely mo	nthly		
Number of set hours to	o work per <u>Wee</u>	<u>k</u> :		;	OR Number	of hours will	vary from	to	per <u>Week</u>		
Wages (Last 6 Pa	avs)										
	-		Harrier		Gross Pay		D		Child Commont		
Period Ending	Date Received	Hours	Hourly Rate	Without Tips, Bonus or Commission		Tips	Bonus or Commission	Garnishmer	nt Child Support Deduction		
	Neceiveu		Nate				Commission		Deduction		
Health Insurance											
Is the employee or the		nrolled in	hoalth incurs	nco?	Begin Date:	End Dat	te: Policy	Number:	Group Number:		
□ No □ Yes	ii dependents t	in oned in	ilcaitii iiisait		Degin Date.	Liid Da	ic. Tolley	Number.	Group Humber.		
Name/Address of Insurance Company:						st Covered Members:					
Name/Address of Insu	rance Company	y:			LIS	t Covered IVI	embers:				
Additional Inforn	nation Need	led For T	Time Peri	nd Bel	ow (See Rev	erse only	v if Time Per	iod is Not	ed Below)		
Time Period Requeste		icu i oi		ou bei		Date:	<u>y II</u> TIIIIC I CI	iou is Not	ca below)		
Employer Signat	ure										
Employer Representative Signature:				Title:			Phone:		AX: Date:		
	-										

<u>If</u> indicated on the front side, please complete the following information <u>for the time period indicated on the front of this form</u> . If it is more convenient or you need more space, you may substitute copies of the employee's payroll records.										
Date Pay Received	Gross Pay Without Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction					
Other Informa Requested Info	ation Requested rmation:									
Employer Resp	onse to Requested Information:									
Employer Rep	D	ate:								
			:							
Phone:			FAX:							
<u> </u>		<u> </u>								

Employee Social Security Number:

Employee Name: